STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		155271	B. WING		03/30/2012			
MAMEOUT	DDOWNER OF GIRDI TEL)	STREET .	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIER	C .	8400 C	LEARVISTA PL				
MILLER'S	S SENIOR LIVING	COMMUNITY	INDIAN	IAPOLIS, IN 46256				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
F0000								
			70000					
	This visit was fo	or a Recertification and	F0000					
	State Licensure S	Survey. This visit						
	included the Inve	estigation of Complaint						
	IN00104878.							
	Complaint IN00	104878: Unsubstantiated						
	due to lack of ev							
	Survey dates: M	Iarch 26, 27, 28, 29, and						
	30, 2012							
	30, 2012							
	Facility number: 000171							
	Provider number							
	AIM number: 10	00267050						
	C							
	Survey team:	N. T. G. 1						
		.NTeam Coordinator						
	1	N. (3/26, 27, 28, 29)						
	Melanie Strycke	r, R.N.						
	Census bed type	· ·						
	SNF14							
	SNF/NF52							
	Total66							
	Census payor typ	pe:						
	Medicare15	_						
	Medicaid46							
	Other5							
	Total66							
	101111 00							
	Sample: 15							
	Sample, 13							
LABORATOR	ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE							

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF CORRECTION IDENTIFICATION NUMBER: 155271	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 03/30	
	PROVIDER OR SUPPLIER S SENIOR LIVING COMMUNITY	8400 C	ADDRESS, CITY, STATE, ZIP CODI LEARVISTA PL IAPOLIS, IN 46256	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on April 4, 2012 by Bev Faulkner, R.N.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DING	00	COMPLETED
		155271	A. BUILDING B. WING		03/30/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	₹		LEARVISTA PL	
MILLER'S	S SENIOR LIVING	COMMUNITY		IAPOLIS, IN 46256	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			
SS=D	INVESTIGATE/F				
	ALLEGATIONS/				
	_	not employ individuals who			
		d guilty of abusing,			
		istreating residents by a court			
		ad a finding entered into the			
		registry concerning abuse,			
	•	tment of residents or			
		of their property; and report			
		t has of actions by a court of mployee, which would			
	_	s for service as a nurse aide			
		staff to the State nurse aide			
	registry or licensing authorities.				
	region y or neeric	ang dationties.			
	The facility must ensure that all alleged violations involving mistreatment, neglect, or				
		injuries of unknown source			
		ation of resident property are			
		ately to the administrator of			
		o other officials in accordance			
	_	rough established			
		uding to the State survey and			
	certification age				
	The facility must	have evidence that all			
		s are thoroughly investigated,			
	_	nt further potential abuse			
		gation is in progress.			
		I investigations must be			
		Idministrator or his			
		esentative and to other			
		dance with State law			
		State survey and certification			
	· ·	working days of the incident,	1		
		d violation is verified	1		
		ective action must be taken.			
	Based on record	review and interview, the	F0225	Miller's Senior Living is reques	sting 04/22/2012
		suspend a C.N.A. from		paper compliance with regards the plan of correction submitte	s to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155271	B. WIN			03/30/2012
					ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF F	PROVIDER OR SUPPLIEF	t .			LEARVISTA PL	
	S SENIOR LIVING			INDIAN	APOLIS, IN 46256	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1	an allegation of verbal			below. F225 Investigation/	
		cient practice had the			Report Allegations/ Individuals Miller's Senior Living respectf	
	potential to impa	act 2 of 2 residents who			submits the following plan of	uny
	were named in 1	of 3 facility			correction as credible allegation	on
	investigations which were reviewed for				of compliance to the above	
	_	olations. [Resident #71			mentioned regulation with pref	fix
	and #72; C.N.A.	-			F225.	
		—1			1.The resident cited in the deficiency no longer reside with the deficiency no longer reside with the deficiency in	th in
	Findings include				the facility.	u
	i indings include	·-			2.The facility reviewed all	
	1 5	,-			allegation of abuse that occur	red
		re-survey meeting on			the past 12 months to ensure	
	1	ts reported to ISDH since			other residents were affected	-
	the last annual su	urvey were reviewed. At			the deficient practice. There v	vere
	the entrance con	ference on 3/26/12 at			no other instances of this	
	10:15 A.M., the	Executive Director was			deficient practice. 3.The "Abuse Prohibition,	
	given the opport	unity to submit the			Reporting and Investigation"	
		cumentation for three of			policy will be reviewed by all	
	1	t reported allegations of			staff. A focus will be placed o	n
	abuse.	order amedamons of			understanding that per the	
	uouse.				Resident Abuse section of the	•
	On 2/26/12 -4 2:	00 D.M. the Execution			"Abuse Prohibition, Reporting	•
		00 P.M., the Executive			Investigation" policy it is require that and staff implicated in an	
	_	d the investigation			allegation of abuse will be	
		or an incident reporting			removed from the facility (not	just
		ouse, and involving			removed from the resident car	•
	Residents #71 ar	nd #72.			area) and suspended until the	
					investigation is completed.	
	The "Unusual O	ccurrence/Incident Report			4.To ensure the deficient practice does not recur, the	
		but was not limited to,			Abuse QA tool (attachment A)	will
	the following: "Incident Date: 12/16/11 Residents				be completed at the time of the	
					investigation. (The reason for	
					prompt completion of an audit	
					tool is related to the fact that the	•
	_	dent #71 and #72]			is an abuse policy.) This tool	
	_	n of Incident: On			be completed by the Corporate	
	12/15/11 at 10:4	5 A.M., the daughter of a			Regional Vice President or his	5

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE S COMPL		
ANDILAN	OI CORRECTION	155271		LDING	00	03/30/	
		100211	B. WIN		A PARAGO CHEMA CHEMA CAN CONT.	00/00/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LEARVISTA PL		
MILLER'S	S SENIOR LIVING	COMMUNITY			APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		social service office to		TAG	designee in conjunction with the		DATE
		social service office to acident overheard last			Administrator at the time of the		
		ween staff member			investigation.		
	• ` ′	patient [Resident #71 or			5.The facility will have all		
	-	ross the hall from her			inservicing completed and auditing in place by April 22,		
	_	daughter, she overheard			2012.		
		N.A. #2] state to patient					
	[Resident #71 or #72], "I don't want to pick you up from the floor, so you better						
	move your ass"						
	Immediate Action Taken: The C.N.A.						
	[C.N.A. #2] who was pointed out by the						
	family was working at the time the						
	incident was reported She [C.N.A. #2]						
	was removed fro	m the floor immediately					
	and an investigat	ion was initiated The					
	C.N.A. was inter	viewed and statements					
	were taken. The	residents who were					
	across the hall or	in close proximity were					
	interviewed as pa	art of the investigation.					
		ould not be confirmed.					
		incidents to report of					
		navior or language. The					
		appy with their care and					
	*	l by this individual.					
		tion showed that the					
	daughter does no						
		y way, but felt it was an					
		tement between staff and					
	resident."						
	A do ouer 4:41:	d "Investigation for					
		d "Investigation for					
	•	s not limited to, the					
	merudea, but was	s not innited to, the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155271			A. BUII	LDING	00	COMPL 03/30/	ETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				_EARVISTA PL		
MILLER'S	S SENIOR LIVING (COMMUNITY			APOLIS, IN 46256		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
1.10		ector of Nursing [DoN]		1.10			5.112
	_	or spoke with [Resident					
		g. When resident asked					
		her stay here and staff					
	_	with her, resident					
		eported that everyone has					
		When asked specifically					
		g of 12/14/11, resident					
	[Resident #71] re	eported the evening went					
	fine DoN and A	Administrator spoke with					
	[Resident #72] th	nis morning. When asked					
about the staff that have cared for her							
	here, she reported	d everyone has been nice.					
	She stated she en	joyed joking with the					
		er heard anyone speak					
	inappropriately o	r use inappropriate					
	language She []	Resident #72] reports she					
	-	C.N.A. #2, who has					
	always been nice	to her"					
	An "Abuse Inves	tigation Worksheet,"					
		ndicated "No actual					
		nvestigation to see if					
	allegation Inter						
	_	physical assessment					
	conducted: Not i	needed; Interview with					
	staff member con	nducted: Not needed					
	Reported because	e investigation done.					
	Never was allega	tion."					
	In an interview o	n 3/27/12 at 10:15 A.M.,					
		rector indicated C.N.A.					
		the Executive Director's					
	•	views were being done					
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155271	B. WIN			03/30/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
MULEDIA					LEARVISTA PL		
	S SENIOR LIVING (INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BEFELECT		DATE
		71 and #72. The C.N.A.					
	^	ed at that time, and					
		ssignment the same day					
		nterviews with Resident					
		e Executive Director					
	1	d not believe that any					
		occurred, based on the					
		Resident #71 and #72 and					
		w with the family					
	member who had reported the incident.						
	She indicated the facility reported the						
	incident because an investigation had						
		o determine if there was					
	an allegation of	verbal abuse.					
	2 771 0 313 H						
	1	Abuse Prohibition,					
		nvestigation Policy and					
		1 1/14/12 was received					
		00 A.M. The policy and					
	_	ed, but was not limited					
	to:						
		: 4. Verbal Abuseis					
		e of oral, written and/or					
		ge that willfully includes					
		derogatory terms to					
		families or within their					
		ess of their age, ability to					
	comprehend, or	disability"					
	3.1-28(d)						

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		IDENTIFICATION NUMBER: 155271	(X2) MULTIPLE CO	00 	COMI	e survey Pleted 0/2012
		19927 1	B. WING			U/2U Z
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COI	DE	
MILLER'S	S SENIOR LIVING	COMMUNITY		LEARVISTA PL APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE PROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT		DATE

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Facility ID: 000171

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155271	B. WIN	G		03/30/	2012
	PROVIDER OR SUPPLIER			8400 CI	ADDRESS, CITY, STATE, ZIP CODE LEARVISTA PL IAPOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	483.13(c) DEVELOP/IMPL ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on record facility failed to Prohibition Policies at the prohibition of abuse allegations practice had the presidents [Resident from a sample of Findings include 1. During the promote of the last annual such the last annual such entrance contains the opportunivestigation doctor the incidents that abuse. On 3/26/12 at 3:6	MENT ABUSE/NEGLECT, develop and implement and procedures that prohibit eglect, and abuse of sappropriation of resident review and interview, the ensure their Abuse eies were followed, fure to suspend an work during the alleged e investigation, for 1 of 3 es reviewed. The deficient potential to affect 2 of 2 ent #71 and #72] eged abuse violations 5.15.	F02		Miller's Senior Living is request paper compliance with regards the plan of correction submitted below. F226 Investigation/Report Allegations/ Individuals Miller's Senior Living respectiff submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefequency no longer reside with the facility. 2. The facility reviewed all allegation of abuse that occurre the past 12 months to ensure the deficient practice. There we no other instances of this deficient practice. 3. The "Abuse Prohibition, Reporting and Investigation" policy will be reviewed by all staff. A focus will be placed or understanding that per the Resident Abuse section of the "Abuse Prohibition, Reporting Investigation" policy it is require that and staff implicated in an allegation of abuse will be removed from the facility (not jet in the section of the graph of the facility (not jet in the paper of the	s to d s - ully on fix th in ed no by vere	04/22/2012
	•	or an incident reporting			removed from the resident car area) and suspended until the	е	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		155271	B. WIN			03/30/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	SR .		8400 CI	LEARVISTA PL		
MILLER'S	S SENIOR LIVING	COMMUNITY		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	· ·		DATE
	_	buse, and involving			investigation is completed. 4.To ensure the deficient		
	Residents #71 and #72.				practice does not recur, the		
					Abuse QA tool (attachment A)	will	
		Occurrence/Incident Report			be completed at the time of the		
		, but was not limited to,			investigation. (The reason for		
	the following:				prompt completion of an audit tool is related to the fact that the	nis	
	"Incident Date: 12/16/11 Residents				is an abuse policy.) This tool to be completed by the Corporate		
	Involved: [Res	ident #71 and #72]			Regional Vice President or his	;	
	Brief Description of Incident: On 12/15/11 at 10:45 A.M., the daughter of a resident came to social service office to report a verbal incident overheard last				designee in conjunction with the		
					Administrator at the time of the investigation.	9	
					5.The facility will have all		
					inservicing completed and		
	_				auditing in place by April 22,		
					2012.		
		•					
	_						
	move your ass						
	1	on Taken: The C.N.A.					
	[C.N.A. #2] w	who was pointed out by the					
		king at the time the					
	1	•					
	_	om the floor immediately					
		•					
	_	erviewed and statements					
		e residents who were					
	across the hall of	or in close proximity were					
		• •					
	_	could not be confirmed.					
		ehavior or language. The					
	night (12/14) be [C.N.A. #2] and Resident #72] a mother. Per the staff member [C [Resident #71 o pick you up from move your ass Immediate Acti [C.N.A. #2] w family was wor incident was repwas removed from and an investigate C.N.A. was into were taken. The across the hall cointerviewed as particularly that the comment of the residents had not be accomment to the residents had not be accommendately the residents had no	etween staff member d patient [Resident #71 or cross the hall from her e daughter, she overheard [C.N.A. #2] state to patient or #72], "I don't want to m the floor, so you better ." on Taken: The C.N.A. who was pointed out by the king at the time the ported She [C.N.A. #2] om the floor immediately ation was initiated The erviewed and statements e residents who were or in close proximity were part of the investigation. could not be confirmed.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155271	A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL 03/30/	ETED
		100271	B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE	00,00	
NAME OF F	PROVIDER OR SUPPLIER				EARVISTA PL		
MILLER'S	S SENIOR LIVING	COMMUNITY		INDIANA	APOLIS, IN 46256		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
TAG		appy with their care and		IAG	DEFICIENCE)		DATE
		by this individual.					
	Further investigation showed that the						
	daughter does no						
	_	y way, but felt it was an					
	_	tement between staff and					
	resident."						
	resident.						
	A document titled "Investigation for						
	Allegation of Abuse on 12/15/11"						
	included, but was not limited to, the						
	following: "Director of Nursing [DoN]						
	and Administrator spoke with [Resident						
	#71] this mornin	g. When resident asked					
	in general about	her stay here and staff					
	that have worked	I with her, resident					
	[Resident #71] re	eported that everyone has					
	1	When asked specifically					
	·	g of 12/14/11, resident					
	l -	eported the evening went					
		Administrator spoke with					
	1 2	nis morning. When asked					
		at have cared for her					
	1	d everyone has been nice.					
		joyed joking with the					
		er heard anyone speak					
		or use inappropriate					
		Resident #72] reports she					
		C.N.A. #2, who has					
	always been nice	e to ner"					
	An "Abuse Inves	stigation Worksheet,"					
		ndicated "No actual					
	· ·	nvestigation to see if					

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NAME OF PROVIDER OR SUPPLIER MILLER'S SENIOR LIVING COMMUNITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP CODE 8400 CLEARVISTA PL INDIANAPOLIS, IN 46256 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMPLETION CROSS-REFERENCE TO THE APPROPRIATE		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155271	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	COMP	ESURVEY LETED D/2012
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) allegation Interview with other residents and/or physical assessment conducted: Not needed; Interview with				STRE 8400	0 CLEARVISTA PL	CODE	
residents and/or physical assessment conducted: Not needed; Interview with	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
Reported because investigation done. Never was allegation." In an interview on 3/27/12 at 10:15 A.M., the Executive Director indicated C.N.A. #2 was placed in the Executive Director's office while interviews were being done with Residents #71 and #72. The C.N.A. was not suspended at that time, and returned to her assignment the same day after the initial interviews with Resident #71 and #72. The Executive Director indicated they did not believe that any verbal abuse had occurred, based on the interviews with Resident #71 and #72 and a further interview with the family member who had reported the incident. She indicated the facility reported the incident because an investigation had been done only to determine if there was an allegation of verbal abuse. 2. The facility "Abuse Prohibition, Reporting, and Investigation Policy and Procedure," dated 1/14/12, was received on 3/26/12 at 11:00 A.M. The policy and procedure included, but was not limited to: "Resident Abuse Procedure: The charge		residents and/or conducted: Not staff member con Reported becaus Never was allegated in an interview of the Executive Di #2 was placed in office while interwith Residents # was not suspender returned to her at after the initial in #71 and #72. The indicated they diverbal abuse had interviews with I a further interview member who had She indicated the incident because been done only than allegation of was	physical assessment needed; Interview with nducted: Not needed e investigation done. ation." on 3/27/12 at 10:15 A.M., rector indicated C.N.A. the Executive Director's rviews were being done 71 and #72. The C.N.A. ed at that time, and ssignment the same day atterviews with Resident are Executive Director d not believe that any accurred, based on the Resident #71 and #72 and aw with the family d reported the incident. The facility reported the an investigation had so determine if there was verbal abuse. Abuse Prohibition, investigation Policy and d 1/14/12, was received the policy and ded, but was not limited				

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	of Correction identification number: 155271	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 03/30	LETED
	PROVIDER OR SUPPLIER S SENIOR LIVING COMMUNITY	8400 CI	ADDRESS, CITY, STATE, ZIP COE LEARVISTA PL APOLIS, IN 46256	DE .	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	nurse is responsible to immediately notify the administrator and Director of Nurses of the situation Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until the investigation is completed" 3.1-28(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155271	B. WIN	G		03/30/	2012
	PROVIDER OR SUPPLIER			8400 C	ADDRESS, CITY, STATE, ZIP CODE LEARVISTA PL IAPOLIS, IN 46256	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0253 SS=D	SERVICES The facility must maintenance ser a sanitary, order! Based on observer record review, the proper cleanle foot board for 1 of utilized this position sample of 15 resisted [Resident #63] Findings include On 3/26/12 at 2:0 tour was initiated Director, Maintenance, Maintenance attendance. On 3/26/12 at 2:0 cushion, position pedals, was obsessmeared stained at that time, the indicated the who Resident #63. In an interview of L.P.N. #3 indicated	200 P.M., environmental d with the Executive nance Director, and the reeping Manager in 40 P.M., a foot board and on the wheelchair rived to have brown, areas. Maintenance Director eelchair belonged to an 3/26/12 at 2:45 P.M., and the soiled areas on the from the resident's toe,	F02	53	Miller's Senior Living is requesting paper compliance with regards to the plan of correction submitted below. F253 Housekeeping and Maintenant Services — Miller's Senior Living respectfully submits the following plan of correct as credible allegation of compliance the above mentioned regulation with prefix F253. 1.Resident # 63 had his foot board replaced with a material that will continue to provide padding but that a surface that can be wiped and sanitized should it be come soiled. 2.All residents with positioning devices have had their devices inspected to ensure they are not soil 3.All staff will be educated on the importance of immediately replacing cleaning any positioning devices the become soiled. 4.To ensure the deficient practice does not recur, an audit tool titled Positional Devices was put into place (attachment B). This audit tool will be completed by the DON or designee daily for 30 days then weekly for 4 weeks, and monthly thereafter. It wereviewed by the QA team at that tim determine the need to continue. 5.The facility will have all inservicic completed and auditing in place by 22, 2012.	tion to to that has filed. g or at the be	04/22/2012

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	of Correction identification number: 155271	(X2) MULTIPLE CO. A. BUILDING B. WING	00	COMPLE 03/30/2	TED
	PROVIDER OR SUPPLIER S SENIOR LIVING COMMUNITY	8400 CL	DDRESS, CITY, STATE, ZIP CODE LEARVISTA PL APOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	The clinical record for Resident #63 was reviewed on 3/29/12 at 12:45 P.M. Diagnoses included, but were not limited to, Parkinson's disease, diabetes, cerebral vascular accident [stroke], right hand contracture, left foot drop, and senile dementiaAlzheimer's type. The resident was admitted to an acute hospital on 3/5 and 3/17/12, with returns to the facility on 3/10 and 3/20/12 for respiratory and blood sugar issues. An electronic record progress note, dated 3/20/12, indicated "Cleanse open area left great toeleave open to air." On 3/23/12, the physician changed the treatment order to "Start Santyl [a topical debriding enzyme]." 3.1-19(f)(5)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETI				
155271			B. WING 03/30/2012				
NAME OF PROVIDER OR SUPPLIER MILLER'S SENIOR LIVING COMMUNITY				8400 CI	ADDRESS, CITY, STATE, ZIP CODE LEARVISTA PL APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371 SS=F	The facility must (1) Procure food considered satis local authorities; (2) Store, prepar under sanitary or Based on observer record review, the open liquids in 1 to date scooped in freezer, failed to concentration of disinfectant] solution, and fail from cleaning so preparation areas impacted 1 of 1 fthe potential to a of the facility which with the highest properties include 1. On 3/26/12 at the kitchen was in Manager. On 3/26/12 at 10 open liquids wer "preparation" or pitcher of "House"	from sources approved or factory by Federal, State or and e, distribute and serve food onditions ation, interview and he facility failed to date of 2 refrigerators, failed ce cream in 1 of 1 ensure proper Quaternary [chemical ation in 1 of 3 buckets of ed to prepare food away flution in 1 of 1 had feed to feed to prepare food food at the facility kitchen and had feed feed food from the	F03	71	Miller's Senior Living is request paper compliance with regards the plan of correction submitted below. F 371 Food Procure, Store/Serve- Sanitary — Miller Senior Living respectfully submit the following plan of correction credible allegation of compliant to the above mentioned regulation with prefix F371. 1.All residents that were senout of the Kitchen that particuladay had the potential to be affected by the deficient praction. 1.Dates and labels were immediately placed on the unlabeled and undated items. 2.The Quaternary Solution was remixed to ensure the bure contained the proper concentration of chemical. 3.The buckets were immediately placed in a designated area away from the food preparation area. 2.Again, All residents that we served out of the Kitchen that particular day had the potential be affected by the deficient practice and the above mention corrections were completed immediately. 3.All dietary staff will be	s to d 's mits n as ice ved ar ce. n cket	04/22/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED	
 155271		B. WIN			03/30/2012	
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8			LEARVISTA PL	
MILLER'S	S SENIOR LIVING	COMMUNITY			APOLIS, IN 46256	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	of prune juice.				educated on: 1. the importance of datir	.a
					and labeling all open items.	19
	At that time, in a	an interview, the Dietary			2.The proper procedure f	or
	Manager indicate	ed staff usually date all			mixing the Quaternay Solution	
	open liquids, and	d the house shake and			and proper procedure for testi	
	tomato juice wer	re just prepared and			the concentration of the chemi	cal
	· ·	chers. She indicated the			to ensure they are at an appropriate level.	
	1 ^ ^	on was just opened by			3.Designated areas for	
	1 *	I the nursing staff failed			placement of the Quaternay	
	to date the cartor	· ·			Solution buckets were identifie	ed.
					Staff were educated on these	
	On 3/26/12 at 10):35 A.M., 3 trays of			designated areas. 4.To ensure the deficient	
		ice cream were observed			practice does not recur, an au	Hit
	in the freezer with				tool titled "State Survey Plan of	
	in the neezer wi	mout a date.			Correction 2012 QA Tool"	
	A1	ta ta a			(Attachment C) will be comple	ted
	· ·	nn interview with the			by the Dietary Manager or	
		r, she indicated dietary			designee 5 times per week for weeks, weekly for 6 weeks and	
	staff know to dat	te all prepared food.			monthly thereafter.	4
					5.The facility will have all	
):40 A.M., 1 bucket of			inservicing completed and	
	Quaternary [cher	mical disinfectant] was			auditing in place by April 22,	
	observed sitting	on the shelf where food			2012.	
	[celery and onion	ns] were being prepared				
	for the next mea	l. The concentration at				
	that time was ch	ecked by the Dietary				
	Manager with the facility testing strips. The concentration read 100 parts per million [ppm] [the correct concentration =					
	150 - 200 ppm].					
	150 200 ppilij.					
	At that time, in a	nn interview, the Dietary				
	· ·	ed staff should not place				
	~	•				
	cleaning solutions near food preparation and staff mixed the concentration					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLI	E CONSTRUCTION		TE SURVEY MPLETED
155271		A. BUILDING	00		30/2012	
100271			B. WING	ET ADDRESS, CITY, STATE, ZI	_	00/2012
NAME OF I	PROVIDER OR SUPPLIE	R) CLEARVISTA PL	IF CODE	
MILLER'S	S SENIOR LIVING	COMMUNITY		ANAPOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TO DEFICIENCY	HE APPROPRIATE	COMPLETION DATE
TAG		indicated the correct	IAG			DATE
	1	ould be 200 ppm.				
	concentration sn	ould be 200 ppin.				
	2. The Retail Fo	ood Establishment				
		irements, Title 410 IAC				
	_	1. (a) included, but was				
		refrigerated, ready-to-eat,				
	-	rdous food prepared and				
		ood establishment for				
		urs shall be clearly				
		ate the date or day by				
	which the food s	shall be consumed"				
	3.1-21(i)(3)					
	3.1-21(1)(3)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00 COMPLETED			ETED	
		155271	A. BUILDING B. WING 03/30/2012			2012	
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MULEDIO	O O CENTRO DE LIVERIO E	CONTRACTOR IN CONTRACTOR			LEARVISTA PL		
MILLER'S	S SENIOR LIVING (COMMUNITY		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	483.65					,	
SS=E	INFECTION CO	NTROL, PREVENT					
	SPREAD, LINEN	IS					
	•	establish and maintain an					
		Program designed to					
		anitary and comfortable					
		to help prevent the					
	•	d transmission of disease					
	and infection.						
	(-) Infortion Ora	tool Due sugges					
	(a) Infection Con						
	Control Program	establish an Infection					
	•	controls, and prevents					
	infections in the						
		t procedures, such as					
		be applied to an individual					
	resident; and	be applied to all illulvidual					
	·	ecord of incidents and					
		s related to infections.					
		o rolatea to illicollorio.					
	(b) Preventing S	pread of Infection					
		ection Control Program					
	· ,	a resident needs isolation to					
		ad of infection, the facility					
	must isolate the	resident.					
	(2) The facility m	ust prohibit employees with a					
	communicable d	isease or infected skin					
	lesions from dire	ct contact with residents or					
	their food, if direct	ct contact will transmit the					
	disease.						
		ust require staff to wash their					
hands after each direct resident contact for							
		ning is indicated by accepted					
	professional prac	ctice.					
	(a) Linana						
	(c) Linens	handla atora process and					
		handle, store, process and					
	of infection.	so as to prevent the spread					
			EO4	4.1	Millor's Conjor Living is requesting		04/22/2012
		ation and interview, the	F04	+1	Miller's Senior Living is requesting paper compliance with regards to the	<u>.</u>	04/22/2012
	facility failed to	ensure the ice scoop was			FEFE COMPRESSION WITH TOGGET GO TO THE	-	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
ANDIEM	or condection	155271	A. BUILDI	ING		03/30/	
			B. WING	CTDEET A	DDBESS CITY STATE ZID CODE	00.00.	
NAME OF I	PROVIDER OR SUPPLIEF	R			DDRESS, CITY, STATE, ZIP CODE EARVISTA PL		
MILLER'S	S SENIOR LIVING	COMMUNITY			APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	plan of correction submitted below.		DATE
		of 1 ice chest, on 1 of 2			plan of correction submitted below.		
		ient practice had the					
	1 ^	et 52 residents who			F 441 Infection Control, Prevent and Spread –		
		econd floor, of 66			•		
		ly residing in the facility			Miller's Senior Living respectfully submits the following plan of correct	ion	
	who were provide	led ice.			as credible allegation of compliance		
	Findings include	:			the above mentioned regulation with prefix F441.		
					1.To correct the deficient practice	the	
On 3/27/12 at 2:00 P.M., the					ice scoop was immediately removed		
	environmental tour was initiated with the				from the ice and the ice chest was removed from the floor to be cleaned	d.	
	Executive Direct	tor. Maintenance			2.All residents had the potential to	be	
		nance Assistant #1, and			effected by the deficient practice. All chests were audited to ensure the	II ice	
	•	usekeeping Manager.			scoop was not located in the ice che	st	
	the regional rio	usenceping manager.			and was properly placed to avoid		
	On 3/27/12 at 2:	35 P.M., a portable ice			infection control concerns. 3.Systemic changes were put in pl	ace	
		oserved in the hallway on		by relocating the ice chest to be			
		The scoop used to			in a locked area. It will only remove from the locked area while it is being		
		om the chest was inside			cleaned, filled, or while ice is being	,	
		d positioned on top of the			passed. This will ensure that no visi have the potential to cause an infect		
		a positioned on top of the			control violation. All staff will be		
	ice.				inserviced on this systemic change a		
	To an intervie	A Abrah Alima Abra Direction			the importance of proper storage of ice scoop (as to not be located in the		
		at that time, the Executive			chest).		
		ed nursing staff were not			4.To ensure the deficient practice does not recur, an audit tool titled		
		the scoop in the ice chest.			"Infection Control/ Ice Scoop"		
		emoved from the ice			(Attachment D) will be completed by	the	
	· ·	he scoop and ice chest			DON or designee daily for 30 days, weekly for 4 weeks, monthly for 3		
		red from the floor by the			months. The QA team will review th		
	Executive Direct	tor for cleaning.			audits at that time to determine if it is necessary to continue this QA tool.	5	
					5.The facility will have all inservicing	-	
	3.1-18(b)(1)				completed and auditing in place by A 22, 2012.	April	
					, _ v ·= ·		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155271	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 30/2012
MILLER'S	ROVIDER OR SUPPLIE S SENIOR LIVING	COMMUNITY	8400 CI	ADDRESS, CITY, STATE, ZIP C LEARVISTA PL APOLIS, IN 46256	CODE	
PREFIX (EACH DEFICIENC		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE

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